organization that is providing benefits under a reasonable cost reimbursement contract under section 1395mm(h) of this title and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395–21(a)(2)(A)(i) of this title and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

(3) Bids not included in determining national average monthly bid amount

The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

(f) Application to PACE

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1395eee of this title that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395w–21(a)(2)(A)(ii) of this title and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

(3) Bids not included in determining standardized bid amount

The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–21, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2122.)

§ 1395w–132. Special rules for employer-sponsored programs

(a) Subsidy payment

(1) In general

The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(2) Qualified retiree prescription drug plan defined

For purposes of this subsection, the term ''qualified retiree prescription drug plan'' means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

(A) Attestation of actuarial equivalence to standard coverage

The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1395w–111(c) of this title) is at least equal to the actuarial value of standard prescription drug coverage, not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(B) Audits

The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1395w–102(d)(3) of this title shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

(C) Provision of disclosure regarding prescription drug coverage

The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1395w–113(b)(6)(B) of this title.

(3) Employer and union special subsidy amounts

(A) In general

For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is,

for the portion of the retiree's gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

(B) Cost threshold and cost limit applicable

(i) In general

Subject to clause (ii)—

(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(ii) Indexing

The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1395w–102(b) of this title.

(C) Definitions

For purposes of this paragraph:

(i) Allowable retiree costs

The term ''allowable retiree costs'' means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

(ii) Gross covered retiree plan-related prescription drug costs

For purposes of this section, the term ''gross covered retiree plan-related prescription drug costs'' means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

(iii) Coverage year

The term ''coverage year'' has the meaning given such term in section 1395w–115(b)(4) of this title.

(4) Qualifying covered retiree defined

For purposes of this subsection, the term ''qualifying covered retiree'' means a part D eligible individual who is not enrolled in a prescription drug plan or an MA–PD plan but is covered under a qualified retiree prescription drug plan.

(5) Payment methods, including provision of necessary information

The provisions of section 1395w–115(d) of this title (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1395w–115(b) of this title.

(6) Construction

Nothing in this subsection shall be construed as—

(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA–PD plan;

(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA–PD plan on behalf of such an individual;

(C) preventing such employment-based retiree health coverage from providing coverage—

(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA–PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA–PD plan; or

(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

(b) Application of MA waiver authority

The provisions of section 1395w–27(i) of this title shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage.

(c) Definitions

For purposes of this section:

(1) Employment-based retiree health coverage

The term ''employment-based retiree health coverage'' means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

(2) Sponsor

The term ''sponsor'' means a plan sponsor, as defined in section 1002(16)(B) of title 29, in

relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

(3) Group health plan

The term ''group health plan'' includes such a plan as defined in section 1167(1) of title 29 and also includes the following:

(A) Federal and State governmental plans

Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5.

(B) Collectively bargained plans

Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

(C) Church plans

Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–22, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2125; amended Pub. L. 111–152, title I, § 1101(b)(4), Mar. 30, 2010, 124 Stat. 1039.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(C), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2010—Subsec. (a)(2)(A). Pub. L. 111–152 inserted before period at end '', not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title''.

STUDY ON EMPLOYMENT-BASED RETIREE HEALTH COVERAGE

Pub. L. 108–173, title I, § 111, Dec. 8, 2003, 117 Stat. 2174, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct an initial and final study under this subsection [probably should be this section] to examine trends in employment-based retiree health coverage (as defined in [sic] 1860D–22(c)(1) of the Social Security Act [42 U.S.C. 1395w–132(c)(1)], as added by section 101), including coverage under the Federal Employees Health Benefits Program (FEHBP), and the options and incentives available under this Act [see Tables for classification] which may have an effect on the voluntary provision of such coverage.

''(b) CONTENT OF INITIAL STUDY.—The initial study under this section shall consider the following:

''(1) Trends in employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003].

''(2) The opinions of sponsors of employment-based retiree health coverage concerning which of the options available under this Act [see Tables for classification] they are most likely to utilize for the provision of health coverage to their medicare-eligible retirees, including an assessment of the administrative burdens associated with the available options.

''(3) The likelihood of sponsors of employment-based retiree health coverage to maintain or adjust their levels of retiree health benefits beyond coordination with medicare, including for prescription drug coverage, provided to medicare-eligible retirees after the date of the enactment of this Act.

''(4) The factors that sponsors of employment-based retiree health coverage expect to consider in making decisions about any changes they may make in the health coverage provided to medicare-eligible retirees.

''(5) Whether the prescription drug plan options available, or the health plan options available under the Medicare Advantage program, are likely to cause employers and other entities that did not provide health coverage to retirees prior to the date of the enactment of this Act to provide supplemental coverage or contributions toward premium expenses for medicare-eligible retirees who may enroll in such options in the future.

''(c) CONTENTS OF FINAL STUDY.—The final study under this section shall consider the following:

''(1) Changes in the trends in employment-based retiree health coverage since the completion of the initial study by the Comptroller General.

''(2) Factors contributing to any changes in coverage levels.

''(3) The number and characteristics of sponsors of employment-based retiree health coverage who receive the special subsidy payments under section 1860D–22 of the Social Security Act [42 U.S.C. 1395w–132], as added by section 101, for the provision of prescription drug coverage to their medicare-eligible retirees that is the same or greater actuarial value as the prescription drug coverage available to other medicare beneficiaries without employment-based retiree health coverage.

''(4) The extent to which sponsors of employment-based retiree health coverage provide supplemental health coverage or contribute to the premiums for medicare-eligible retirees who enroll in a prescription drug plan or an MA–PD plan.

''(5) Other coverage options, including tax-preferred retirement or health savings accounts, consumer-directed health plans, or other vehicles that sponsors of employment-based retiree health coverage believe would assist retirees with their future health care needs and their willingness to sponsor such alternative plan designs.

''(6) The extent to which employers or other entities that did not provide employment-based retiree health coverage prior to the date of the enactment of this Act [Dec. 8, 2003] provided some form of coverage or financial assistance for retiree health care needs after the date of the enactment of this Act.

''(7) Recommendations by employers, benefits experts, academics, and others on ways that the voluntary provision of employment-based retiree health coverage may be improved and expanded.

''(d) REPORTS.—The Comptroller General shall submit a report to Congress on—

''(1) the initial study under subsection (b) not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]; and

''(2) the final study under subsection (c) not later than January 1, 2007.

''(e) CONSULTATION.—The Comptroller General shall consult with sponsors of employment-based retiree health coverage, benefits experts, human resources professionals, employee benefits consultants, and academics with experience in health benefits and survey research in the development and design of the initial and final studies under this section.''

§ 1395w–133. State Pharmaceutical Assistance Programs

(a) Requirements for benefit coordination

(1) In general

Before July 1, 2005, the Secretary shall establish consistent with this section requirements for prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

(A) payment of premiums and coverage; and

(B) payment for supplemental prescription drug benefits,

for part D eligible individuals enrolled under both types of plans.

(2) Coordination elements

The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

(A) Enrollment file sharing.

(B) The processing of claims, including electronic processing.

(C) Claims payment.

(D) Claims reconciliation reports.

(E) Application of the protection against high out-of-pocket expenditures under section 1395w–102(b)(4) of this title.

(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

(3) Use of lump sum per capita method

Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

(4) Consultation

In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

(5) Part D plan defined

For purposes of this section and section 1395w–134 of this title, the term ''part D plan'' means a prescription drug plan and an MA–PD plan.

(b) State Pharmaceutical Assistance Program

For purposes of this part, the term ''State Pharmaceutical Assistance Program'' means a State program—

(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

(3) which satisfies the requirements of subsections (a) and (c).

(c) Relation to other provisions

(1) Medicare as primary payor

The requirements of this section shall not change or affect the primary payor status of a part D plan.

(2) Use of a single card

A card that is issued under section 1395w–104(b)(2)(A) of this title for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such connection.

(3) Other provisions

The provisions of section 1395w–134(c) of this title shall apply to the requirements under this section.

(4) Special treatment under out-of-pocket rule

In applying section 1395w–102(b)(4)(C)(ii) of this title, expenses incurred under a State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

(5) Construction

Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

(d) Facilitation of transition and coordination with State Pharmaceutical Assistance Programs

(1) Transitional grant program

The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

(2) Use of funds

Payments under this section may be used by a Program for any of the following:

(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

(3) Allocation of funds

Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.